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v. 5-17-39  
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FILED FEB 17 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2848

Registration District No. 398

Primary Registration District No. 3019

Registrar's No. 26

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH:**

(a) County Jackson

(b) City or town Independence  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 112 9th Dodge  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 years (Specify whether years, months or days)

In this community 3 years

8. (a) PRINT FULL NAME LAURA Mosier

3. (b) If veteran, name war None

8. (c) Social Security No. None

4. Sex Female

5. Color White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife allc

6. (c) Age of husband or wife if allc years

7. Birth date of deceased April 26, 1862  
(Month) (Day) (Year)

8. AGE: Years 78 Months 8 Days 22 If less than one day hr. min.

9. Birthplace Milledgeville, Georgia  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business ✓

MOTHER FATHER

12. Name no record

13. Birthplace no record 9  
(City, town, or county) (State or foreign country)

14. Maiden name no record

15. Birthplace no record 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ethel Rowland

(b) Address 1110 W. Walnut

17. (a) Burial, cremation, or removal burial (b) Date thereof 20/41  
(Month) (Day) (Year)

(c) Place: burial or cremation Wood Grove

18. (a) Signature of funeral director George C. Carson

(b) Address Independence, Mo.

19. (a) Jan 20 '40 (b) F. L. Cook M.D.  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson

(c) City or town Independence  
(If outside city or town limits, write "RURAL")

(d) Street No. 112 9th Dodge  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan - day 18  
year 1941 hour 5:50 minute 11 A. M.

21. I hereby certify that I attended the deceased from Jan 10, 1941, to Jan 18, 1941; that I last saw her alive on Jan 16, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis  
Brucellosis

Due to dietsitinal obstruction

Due to ?

Other conditions (include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations

Of autopsy

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? 3600  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? While at work?  
(Specify type of place) (e) Means of injury

23. Signature C. S. Gillison (M. D. or other) 11  
Address 12317 Independence Ave Date signed 1/19/41

93 D

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *Ralph E. Miller*

Licensed Embalmer No. *4124*

P. O. Address..... *3rd St. No.*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Independence  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME Laura Mosier

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 78 Months 8 Days 22 If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

Medical CERTIFICATION

20. DATE OF DEATH: Month Jan day 18  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Duration \_\_\_\_\_

Broncho Pneumonia

Due to \_\_\_\_\_

Intestinal Obstruction

Due to \_\_\_\_\_

probable Carcinoma of sigmoid colon

Other conditions \_\_\_\_\_ (Include pregnancy within 7 months of death)

Major findings: 469

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Stellman (M. D. or other) M.D.

Address 10307 Indef Ave Date signed 1/14

SUPPLEMENTARY

